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Racial i(nter)dentification: The racialization of maternal health through the Oportunidades program and in government clinics in México

I(nter)dentificación racial: racialización de la salud materna a través del programa Oportunidades y clínicas gubernamentales en México

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ABSTRACT Using an ethnographic approach, this article examines the role of racialization in health-disease-care processes specifically within the realm of maternal health. It considers the experiences of health care administrators and providers, indigenous midwives and mothers, and recipients of conditional cash transfers through the *Oportunidades* program in Mexico. By detailing the delivery of trainings of the Mexican Social Security Institute (IMSS) [*Instituto Mexicano del Seguro Social*] for indigenous midwives and *Oportunidades* workshops to indigenous stipend recipients, the article critiques the deployment of "interculturality" in ways that inadvertently re-inscribe inequality. The concept of racial i(nter)dentification is offered as a way of understanding processes of racialization that reinforce discrimination without explicitly referencing race. Racial i(nter)dentification is a tool for analyzing the multiple variables contributing to the immediate mental calculus that occurs during quotidian encounters of difference, which in turn structures how individuals interact during medical encounters. The article demonstrates how unequal sociohistorical and political conditions and differential access to economic resources become determinants of health.

KEY WORDS Race; Indigenous Health Services; Maternal Health; Traditional Birth Attendant; Mexico.

RESUMEN Desde un abordaje etnográfico, este artículo examina el papel de la racialización en los procesos de salud-enfermedad-atención-cuidado, específicamente dentro del ámbito de la salud materna, a partir de las experiencias de los proveedores y administradores de salud, parteras y madres indígenas y las receptoras de transferencias monetarias condicionadas a través del programa Oportunidades. Al analizar las capacitaciones del Instituto Mexicano del Seguro Social (IMSS) a parteras indígenas y de los talleres del programa Oportunidades para personas indígenas, este artículo critica la utilización de la "interculturalidad" a través de formas que reafirman inadvertidamente la desigualdad. El concepto de i(nter)dentificación racial se ofrece como una manera para entender los procesos de racialización que refuerzan la discriminación sin hacer referencia explícita a la raza. La i(nter)dentificación racial es una herramienta para el análisis de variables múltiples que contribuyen al análisis interno inmediato que ocurre durante encuentros cotidianos con la diferencia, lo cual también estructura cómo los individuos interactúan durante los encuentros médicos. Este artículo muestra cómo las condiciones sociohistóricas y políticas desiguales y el acceso diferencial a los recursos económicos se convierten en determinantes de la salud.

PALABRAS CLAVES Origen Étnico y Salud; Servicios de Salud del Indígena; Salud Materna; Atención Tradicional del Nacimiento; México.

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INTRODUCTION

> *It is the middle of the night in the High Nahua Mountains of Veracruz. A woman arrives at the door, her belly contracting fiercely and regularly. While the contractions send waves of pain throughout her body, she is calm and determined. She and her husband have driven along the dark winding path for several hours, family members piled into the back of their pickup truck, to seek out the midwife. The woman is alert and aware of what could happen, but she is unafraid. She has brought new life into this world many times before—the grey hairs sprouting around her temples evince her years of experience nurturing and raising children. But this time she refuses to be humiliated or shunned. Everyone is quiet, as they are all witnesses to a clandestine act. The midwife has agreed to be an accomplice—she will provide her expertise and aid the woman in her defiant plan. The woman and her husband enter into the midwife's bedroom, and the curtains are drawn behind them. Nothing is heard in the house except for soft whispers of encouragement, until a newborn baby cries out into the black of night.* [Observations of a surreptitious birth that occurred in defiance of Oportunidades program mandates, July 2011]

In this article, I examine the role of racialization in health-disease-care processes,[1] specifically within the realm of maternal health. Through ethnographic observations, I consider the opinions and experiences of health care administrators and providers, indigenous midwives and mothers, and *Oportunidades* program recipients. In doing so, I create a cartography of obstetric violence in which class, gender, and ethnic differences collapse onto one another in ways that lead to some individuals being marginalized as "Others" within health care and government aid settings. In doing so, I demonstrate how unequal sociohistorical and political conditions and differential access to economic resources become determinants of health. By detailing the delivery of trainings of the Mexican Institute of Social Security (IMSS) [*Instituto Mexicano del Seguro Social*] for indigenous midwives and *Oportunidades* workshops for indigenous recipients of conditional cash transfers, I critique the deployment of "interculturality" in ways that inadvertently re-inscribe inequality in Mexican society. Furthermore, I will offer the concept of racial i(nter)dentification as a way of understanding processes of racialization that reinforce discrimination without explicitly referencing race. In essence, I examine how racial discrimination buttresses systemic violence within Mexican obstetrics, thus eliciting complicity from medical personnel, with the greatest violations being unleashed on racialized women's bodies.

The arguments presented in this article are the results of an extensive research project "A Tale of Two Births: Transnational Health Care in Multiethnic Mexico", carried out under the auspices of the University of California, Berkeley. Part of the research results have been published in the article "Commodifying indigeneity: How the humanization of birth reinforces racialized inequality in Mexico."[2]

METHODS

I used multi-sited ethnography to follow the object of midwifery and humanized birth in Mexico,[3,4,5] thus identifying different "windows" through which recent shifts in birth practices and health care can be examined.[6]

My ethnographic research began at a professional midwifery school in central Mexico. However, after joining professional midwifery students and administrators on a "field practice" trip to the High Mountains of Veracruz, I began to think about the issue of place-based differences and the importance geographical location plays in the reproductive care women receive. This required redefining my preconceived notion of an

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ethnographic field site. The field I identified was not a "site" per se, but, rather, a network of people. I began with professional midwives in Mexico, a contained and connected group of women, and subsequently gained access to their clientele. I then recruited couples, physicians, and obstetric nurses, to my study. Over the course of my fieldwork, I volunteered at two different transnational NGOs, gaining access to training workshops for indigenous traditional midwives. Having befriended a few indigenous midwives, and while staying as a guest in their homes during repeat visits to their villages, I was able to witness their interactions with indigenous women and the "traditional" midwifery care they provide. Finally, I observed medical professionals and maternity patients in both private and public hospital settings and solicited interviews with physicians and policy makers. This process led me to the Mexican states of Guanajuato, Guerrero, Jalisco, México, San Luís Potosí, Veracruz, Chiapas, Oaxaca, Quintana Roo, Morelia, Querétaro, Puebla, Michoacán, and Nuevo León; additionally, I travelled to California for interviews, and Brazil for participant observation in a "traditional Mexican midwifery" workshop. While the geographic breadth of this "field" is enormous, the specific people I travelled to meet, observe, and interview were very concrete. All the individuals in my study have acquaintances, and often great friends, among the other individuals in my study.

I conducted in-depth interviews during 28 months of multi-sited research across Mexico, from October 2010 to November 2013. Combining informal interviews, in-depth interviews, and persons whom I have observed, there are 2,069 subjects included in this study. Interviews were semi-structured and lasted from 15 minutes to three hours, with the average being approximately forty-five minutes. I tailored my questions to the interviewees' positionality with respect to birth – according to whether the interviewee(s) was/were a mother, a couple, a birth attendant (traditional midwife, professional midwife, obstetrician, obstetric nurse), or a policy maker – but usually included questions to help me understand the interviewee(s) positionality in society (education level, socioeconomic status, ethnicity, etc.). In addition, my questions generally followed these themes: the interviewee's occupation and life history in addition to their perspectives on gender, the Mexican health system, positive and negative experiences with birth, and the shifting political climate regarding midwifery. By not over-structuring the interviews, I resisted scripting or leading the informants, allowing them to speak for themselves.

My data analysis is derived from detailed entries in my field diary, and audio and video recordings from interviews. Upon concluding my research, I engaged in an iterative process that used open coding to identify emergent themes and synthesize higher order constructs. I have changed names and concealed identifying markers of all informants in order to preserve the anonymity and confidentiality of research data. Informed consent was obtained from informants throughout the course of the research, in accordance with the regulations stipulated by the Committee for Protection of Human Subjects at the University of California, Berkeley (Protocol Number: 2011-02-2912).

"OTHERING": PROVISION OF MATERNAL HEALTH CARE ACROSS MEXICO

During my fieldwork, I discovered that the dynamic of othering is both marked and salient between health providers and the people they are meant to serve. While in San Miguel, I was invited to a directors' meeting at an NGO focused on community health. The directors considered "ignorance" and lack of responsibility to be primary obstacles to helping community members improve their health: for example, parents who don't teach their children to eat vegetables and themselves do not eat vegetables, individuals with poor health who do not seek treatment until it is too late, adolescents who forego using

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contraceptives despite the availability of information about their use and effectivity, and mothers who stay home with their newborn during the first week after birth instead of having their neonates tested for hypothyroidism during the short period when long-term consequences can still be prevented. Whether or not healthy food is available to lower-class families, the insufficient infrastructure in hospitals, the accessibility of contraceptives given Mexico's catholic underpinnings, and the benefits and limits of women's embodied knowledge were left out of the discussion. "Ignorance" is not used as the explanatory variable for negative health outcomes only in boardrooms – elsewhere in San Miguel a woman shared a painful miscarriage experience with me, explaining that the nurse at the public hospital scolded her, saying:

> *...you should have known that you were miscarrying. It is your fault that you didn't come sooner*. [Translation from: *tu deberías haber sabido que estabas teniendo un aborto espontáneo, es tu culpa por no haber venido antes*.]

In Veracruz, health professionals blamed vaginal infections on poor hygiene, while women insisted that "it is not the woman's fault." They criticized their patient population for being bad "sanitary subjects,"[7] placing themselves at risk, not understanding medical advice, and needing to be told things "real slow." Throughout my fieldwork, I noticed how physicians explained their diagnoses and treatment options in "colloquial" terms, which often meant giving incorrect information. In turn, this was interpreted by patients as lying and breeded distrust and avoidance of hospitals all together. Examples are telling indigenous people that an injection contains "vitamins" and that baby must be born quickly or it will die.

In Guerrero, I sat in on a meeting between Secretary of Health officials about incorporating professional midwives into public hospitals and rural clinics. At the conclusion of the meeting, one official summed up the Secretary of Health's progress in the area of women's reproductive health by saying that people in villages are "*too closed-minded*," making it impossible for them to do their work. I visited a regional hospital in one of the impoverished, indigenous zones that these officials are responsible for overseeing and spoke to a physician about the difficulties he faces when treating patients. He said, simply,

> *...their problem is themselves. They are their problem*. [Translation from: *...el problema son ellos mismos, ellos son su problema*.]

Again and again, health professionals told me how difficult it was to work with *indígenas* [indigenous people] due to their "distrusting" culture.

In San Luis Potosí I visited a rural hospital in a Huastec zone. The professional midwife working there – herself a person of Huastec heritage and a speaker of the Téenek language – told me that a large number of adolescents are giving birth in that hospital. Some of the birthing mothers she attends, she asserted, do not even know what body part the baby is emerging from: "*the people around here do not know much*." I am interested in the way this professional midwife positioned herself vis-à-vis the community in which she works and in which she herself was raised. Having graduated from a professional midwifery school in another state, she no longer associated herself with "the people around here." I suggest that the implicit contrast embedded in her word choice served to socially whiten her, thus distancing her from her indigenous roots, even as her "indigeneity" and linguistic ability (and, implicitly, her gender) serve as primary criteria for her placement in that hospital.[8]

Elsewhere in San Luis Potosí, I asked two professional midwives what they hypothesized to be the cause behind a curious number of birth complications and congenital abnormalities in the region. They began listing their hypotheses: Women are not educated, have poor diets and don't drink enough water, don't take folic acid, they

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don't seek regular prenatal care, have poor hygiene leading to vaginal infections, and perform physical labor during pregnancy. One professional midwife said,

> *The patients are uncultured. They don't come for medical examinations. Also, they lack education. A lot of women don't even know they are pregnant 32 weeks into their pregnancy*. [Translation from: *las pacientes son incultas, no vienen a las revisiones médicas, y no han recibido educación* [...] *muchas ni saben que están embarazadas a las 32 semanas de gestación*.]

They went on to describe to me how a mother was nursing her newborn in the hospital when a nurse noticed that the baby was purple and not moving and took the baby from the mother. The medical team was able to resuscitate the baby, but if it had not been for the nurse's intervention, the baby would have died in the negligent mother's arms. After they told me this story, I joined them in the operating room, where a woman was having the remnants of a miscarriage scraped from her uterus. Doors on both sides of the operating room were propped open, leaving the woman's naked genitals exposed to those passing by in the hospital corridor.

In Chiapas, I spoke to a health official about maternal deaths. He described recent cases, explaining that the first was a woman whose eclampsia was not identified opportunely because she didn't attend prenatal checkups. In a second case, he was not sure what was the cause of the woman's death, but he knew that the traditional midwife was to blame. In another case, he again was not sure to the actual cause of death, but knew that it was an uneducated woman from a rural area. Lastly, I was told about a maternal death involving a traditional midwife who belonged to a civil association of traditional midwives and had been trained by a local NGO. The traditional midwife attempted to deliver a dystocic baby and broke the baby's neck. I met with many of the traditional midwives in the civil association. They resented being charged with causing maternal mortalities when no investigation is made into the individual cases.

I later spoke to a physician who sees a large number of indigenous female patients. He said,

> *...they lack the economic support to come to the health center and buy medications, but the culture of the people living in the countryside does not allow us to go to them*. [Translation from: *les falta apoyo económico para acudir al centro de salud y comprar las medicaciones, pero la cultura de las personas del campo tampoco nos permite acercarnos a ellos*.]

He identified indigenous peoples' traditions and lack of education as the main reasons why patients and doctors are unable to understand one another. As our conversation broached the overlap between resource scarcity and indigeneity, the doctor reflected aloud on how he chooses whom to attend next from a crowded waiting room. Indigenous patients are less likely to have ready and reliable access to bathing water, and he is more likely to pick someone from the waiting room who has bathed today rather than three days ago; therefore, he tends to pick indigenous patients last, causing them to wait the longest.

In Michoacán, I interviewed a leader of an NGO that advocates for women's health, especially among Purepechan women. He spoke at length about inequality and his words point to how easily indigeneity is collapsed with poverty:

> *...if you ask "are the Purepecha discriminated against?" some people will say no. But...the majority of the Purepecha would say they are routinely discriminated against and looked down upon, or refused service, or delayed service. It's common to have that kind of discrimination. Class is probably, I think, the major issue in Mexico. The disempowerment of poor people*. [Translation from:

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> *...si preguntas: "¿los purépechas sufren de discriminación?", algunas personas dirán que no. Pero... la mayoría de los purépechas dirían que a menudo sí se los discrimina y se los menosprecia, se les niega el servicio, o no se los atiende a tiempo. Es común tener este tipo de discriminación, es común. Creo que la clase social es, probablemente, el mayor problema en México: la indefensión y el desamparo de la gente pobre*.]

While I am sensitive to the effects of colonial legacies unfolding in the present day, I resist carrying out a Fanonian or Hegelian analysis of mutual recognition[9,10,11] – not because I do not consider these analyses valuable, but because I recognize that many others have done illuminating work in this field, and I think it is more productive to use an intersectional approach to address the questions at hand instead of applying the concept of mutual recognition to a Latin American context. In this present analysis, I am positioning myself as a medical anthropologist, and more specifically, as an intersectional scholar of the anthropology of reproduction. Thus, using intersectionality as a lens, I bring ethnographic tools and anthropological theory to bear on racial i(nter)dentification in Mexico, examining the question: What can stratified reproduction[12] tell us about race?

Raza

While others have written about "race" and racialized biology,[13,14,15,16] my work is about the construction of social identities that allow for the gendered manipulation of "race." What is being racialized is not just the biological body or the national body, but also the moral body. Thus, I turn to the work of Marisol de la Cadena and Elizabeth Roberts to argue that *raza* in Latin America is a complex social category that extends beyond "race" to include class, education, and "culture." My argument is not about deciding whether "race" is essentially biological or primarily a social construct – rather, I am concerned with how a history of colonialism in Mexico has opened a space for racialization processes which lead to the production of differential ("race"-infused) identities.

While I resist reducing race to a matter of biology, biological race is used to define the right and wrong types of reproduction, which in turn shapes policy and practice both nationally and transnationally.[17] While medical anthropologists have extensively studied these effects in the realms of international population policy and migration,[18,19,20,21] and have analyzed how nineteenth and twentieth-century battles about slavery, miscegenation, immigration, population control, and eugenics resulted in the categorization of people into fit and unfit reproducers,[22,23,24,25] my work addresses Brubaker and Dillaway's call to:

> ...conduct comparative research on the subjective experiences of pregnant and birthing women at multiple social locations and multiple contexts, as well the experience and perspectives of midwives and medical providers in order to provide a more critical and meaningful analysis of the complicated intersections of ideology, politics, practice and bodily experience.[26]

I employ Robert's notion of *raza* [race] and provide ethnographic examples of how "reproductive governance" is applied to the supposedly hyper-fertile indigenous women. In doing so, my work is informed by a binational discourse critiquing public health systems in Latin America.[4,27,28,29,30,31,32,33,34,35,36] By including medical care as another means to mark and transform race, Roberts[37] is calling attention to the malleability of material reality, and thus critiques tendencies to mark a divide between nature and culture, and assumptions about the universality and fixity of biological processes.[38,39,40,41] She explains that in the Andean context, public health services were developed to intervene upon poor and indigenous populations, and especially hyper-fertile indigenous women.

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[42,43] Thus, while raza is pliant, plastic, and cultivatable in the Andes, it is still used to justify inequality.

Similarly, De la Cadena points to how *raza* is shaped by employment, locale, dress, class, levels of "*decencia*" [decency] and sexual conduct.[44] De la Cadena explains how pervasive racism in Peru is erased, using a rhetoric of cultural difference:

> These exculpations of racism are embedded in a definition of *race* rhetorically silenced by the historical subordination of phenotype to *culture* as a marker of difference. In other words, Peruvians think their discriminatory practices are not racist because they do not connote innate biological differences, but cultural ones.[44]

For De la Cadena, cultures are vessels of immanent inequalities, leading to the mystification of racial discrimination and "racism without race." Culture is achievable, and categories such as Indians and mestizos emerge from interactions and not from evolution. One's phenotype can be subordinated to one's intelligence and morality if these have been corrected by "education." Thus, a brown-skinned individual who is sufficiently educated can become "socially white."[45] With respect to the Mexican context, I do not deny associations between phenotype and how people are identified as racialized beings; however, I expressly resist the idea of "race" *as* phenotype, and signal how "social whitening" is sometimes achieved through the accumulation of cultural capital.

Clark focuses on how educating Indians produced them as national citizens: "By definition Indians were seen as ignorant, because it was assumed that Indians who were educated would automatically become mestizos"[42]. Roberts[17] writes about the entanglement of *raza* and class relations, indicating that

> ...disentangling class and raza would do damage to an ethnographic understanding of care relations in Ecuador. Identifying the kinds of food ingested or care received as social markers of class, misses the way that raza is produced within economic relations.[17]

This article develops the concept of racial i(nter)dentification as a way for thinking about the syncretic nature of racialized identities.[28,29] Racial i(nter)dentification is a tool for analyzing the multiple variables contributing to the immediate, often unconscious, mental calculus that occurs during quotidian encounters of difference, which in turn structures how individuals interact, including during medical encounters. In these moments, "race," class, education, and other forms of cultural capital are folded into one another to produce social constructions of gendered racial identity that include and supersede phenotype. Racial i(nter)dentification explicitly attends to the amalgam of non-biologic elements that are folded into notions of "race."

Furthermore, instead of deploying the concepts of "race" and racism, I am pointing to how racial i(nter)dentification unfolds in and through processes of gendered racialization. That is, throughout this article, I resist the reification of "race" and instead use ethnographic observations to critically analyze intersectional processes of gendered racialization. My approach builds upon a hefty literature on "intersectionality" – the study of how dimensions of inequality co-construct one another, an intersectional way of thinking about the problem of sameness and difference in relation to power, a foundational logic of interlocking oppressions, and an examination of systemic domination that overlaps sexuality, race, gender, economic class, etc.[46,47] According to Granzka, scholars of "strong intersectionality" (as opposed to "weak intersectionality") engage in constant self-reflexivity, wielding the concept as an analytic tool that critiques power and privilege, and producing counter hegemonic knowledge about marginalized and subjugated groups.

Kimberle Crenshaw's analogy of the increased likelihood for injury due to crossing traffic at an intersection elucidates how black women in the United States sometimes

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experience gender discrimination in a similar way to white women, other times they experience racial discrimination similarly to black men, and still other times they are discriminated against as black women – not the sum of racism and sexism, but something that supersedes these individual categories and cannot be described as a derivative of white women's or black men's lives. Crenshaw emphasizes gender discrimination against women who are already marginalized due to race and/or class, and argues that while racialized women face some of the same obstacles that more elite women face, they also encounter obstacles that are unique to them.[48]

My research provides many examples of the "class apartheid" to which Gayatri Spivak refers—the class divisions within individual nations that lead people of the same "culture" to live divergent realities.[49] One of the aims of this article is to draw attention to the complex ways class is embedded in gendered racialization processes, and vice versa, to create multivalent social categories. Among gendered individuals, one may ask if "race" is doing the work of class or if class is doing the work of "race." This article adds complexity to the story by describing how gender, race, and class intersect and are mutually imbricated: that is, among gendered individuals, race does the work of class *and* class does the work of race. Racialization and class, as well as resulting categories like education level and geographic location, are mutually imbricated and compounded in people's lives. That is to say, people cannot experience their positionality in society through only one of these factors; they necessarily structure their identity and their relationships with others through the combination of these intersectional factors.[37,46,50,51,52]

While my description of different positionalities within Mexican society can be compared to Bourdieu's habitus,[53] I have developed racial i(nter)dentification as a way of simultaneously acknowledging the readily visible phenotypic differences between the haves and have nots. I insist that multiple, overlapping, structural inequalities are unfolding; thus, I offer racial i(nter)dentification and intersectionality as multivalent conceptual tools because I refuse to disregard the blatant visual discrepancy between institutional representatives and *Oportunidades* program recipients across Mexico. "Race," gender, and class in Mexico are intimately imbricated, kaleidoscopic categories. Processes of gendered racialization collapse and incorporate a multitude of social factors, yet reducing these processes to a discussion of habitus would obscure apparent phenotypic gaps readily observed throughout my ethnographic research.

In this article, I primarily examine the "race" axis of intersectional forms of oppression. That is, I aim to explore the *racialization* aspect of gendered racialization. I am by no means elevating racialization to the most significant criteria for analysis—socioeconomic class, education level, gender, geographic location, etc. are important, intersecting units of analysis. However, I am suggesting that analyzing racialization in this article will point our attention to how colonial legacies continue to shape identities. Furthermore, by placing emphasis on racialization as an analytical lens, I am questioning how a history of colonialism continues to mold the contemporary transnational order.[54]

Racial i(nter)dentification and the Mexican government

Citizenship is a fertile terrain for negotiation between indigenous women and the Mexican government. These women are recruited into *Oportunidades* and required to give birth in government hospitals. While my observations at times coincided with those of Smith-Oka[55] in that some indigenous women eagerly seek biomedical attention while giving birth – this author argues that *Oportunidades* shapes these poor indigenous women into obedient mothers and "modern" citizens – I interviewed many others who resist mandates due to prior experiences of racial discrimination.

Despite persistent evidence of marginalization of indigenous peoples and examples

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of profit-seeking around constructed images of indigeneity, I am attentive to Clifford's point about dynamism[56,57] – I am careful not to deny indigenous informants and friends of their agency by portraying them *only* as victims. Thus, I am concerned not only with how indigeneity is portrayed by non-indigenous ethnomedicine enthusiasts, but how indigenous individuals portray their own ethnic identities.[2] I suggest that while indigenous people have suffered from centuries-long structural violence, they have also devised strategies for leveraging their indigeneity and, at times, view their indigenous heritage as a source of pride. My perspective does not sanitize the effects of violence and long-standing exclusion, nor does it diminish the agency and dynamism of indigenous individuals; rather, I aim to cast indigenous informants as agentive, proactive people who experience their indigeneity both as a source of marginalization and also as a valuable resource.

The very different ways indigenous women engage medical care undermines ubiquitous arguments for "interculturality" among medical and public health sectors in Mexico. Interculturality in Mexico aims to reduce the effects of xenophobia by incorporating indigenous cultural elements into government-provisioned services. In the following pages I return to how my framing signals the inadequate attention of "interculturality" to gender, racial discrimination, and political economic factors. My concept of racial i(nter)dentification questions the reification of cultures upon which "interculturality" is premised.

Deadly consequences of gendered racialization

When I attended a training workshop for traditional midwives given by Mexican Institute of Social Security in Zongólica, Veracruz, I witnessed a striking moment when a single woman's body became a site of contestation about race, class, gender, and power. The room was divided into two glaringly distinct spaces: male doctors with white coats stood in front of the room, and traditionally-dressed indigenous midwives sat in the audience. An elderly midwife, Paloma, stood up in the very last row. Paloma told a story about how the neglect of medical doctors and staff led to the unnecessary death of an indigenous woman's baby. The pregnant woman had arrived at the hospital in active labor, and the nurses refused to attend to her. The desperate mother rushed to the restroom and gave birth to a stillborn child. The dead infant was born into the toilet. Having never been assigned a hospital bed, she left pools of blood on the hallway floor, and the nurse scolded her for making a mess and forced her to clean up the blood. Paloma ended the wrenching tale by yelling, "*I, too, could put on a white coat!* [Translation from: *yo también puedo ponerme una bata blanca*.]"

The hospital director asked Paloma the name of the community worker involved in the case. When she answered him with the female, indigenous community worker's name, he nodded, as if to say, "Ah, yes," and stated aloud that this community worker has been involved in several unfortunate cases. If the community worker had succeeded in getting the birthing mother to the hospital sooner, he suggested, the case would not have ended tragically. He promised Paloma that he would reprimand the community worker. While this seemed to appease Paloma somewhat, I was less satisfied with this resolution. In a matter of seconds, the female, indigenous community worker became the scapegoat for a health system that is failing at multiple levels. The medical personnel at the hospital were, by a sleight of hand, let off the hook. The hospital director quickly directed the workshop attendees away from this "disruptive" anecdote and toward other matters. However, the incident lingers in my mind. The woman's hemorrhage and the infant's life-that-never-was had been the site of contestation, but they were not the real objects of the debate.

This anecdote bolsters the analysis and critique of Nazar-Beutelspacher's[58] assertion that in Mexico, the approximation of institutional services to indigenous populations is

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an encounter between two cultures, and is embedded in unequal relations with respect to the value of knowledge and distinct medical practices. My ethnographic observations suggest that indigenous and mestizo cultures unfold and evolve through engagement with one another, and are, thus, co-constitute. Indigenous informants contest and shape how their medical practices are valued, at times leveraging "indigenous" knowledge in entrepreneurial ways. At the same time, social collectivities are differentially nested in geographic places and even "racially" segregated in clinical spaces, signaling how material disparities result from structural inequalities.

The incoherency of *Oportunidades*

One particularly elucidative pathway for understanding the relationship between the Mexican government and indigenous groups is through detailed examination of *Oportunidades* conditional cash transfers. Paloma acquiesced following public dispute with the hospital director in Zongólica. However, throughout my research, I observed many midwives' disparate behavior in public and private realms. Traditional midwives and indigenous *Oportunidades* recipients performed obedience in workshop settings while enacting resistance to government mandates in their daily lives. Program successes "front stage" (like widespread attendance to *Oportunidades*-mandated workshops) did not easily translate to changes in social behavior "back stage." Molyneux goes as far as to argue that *Oportunidades* puts mothers at the service of the "new poverty agenda" and inadvertently exacerbates gender inequality when it holds mothers accountable for their childrens' well-being, excuses fathers of responsibility toward their offspring, and provokes marital discord (and potentially domestic violence) by putting cash stipends in the hands of women amidst widespread unemployment of male "providers."[59]

According to Rodrigo, a physician turned Mayan rights advocate and board member of an indigenous association in Chiapas, training workshops offered by the state are meant to reinforce inequality in existing power structures. While the *Oportunidades* program has been lauded within the realm of public health,[60] I argue that the conditionality of cash transfers evidences differential valorization of knowledge and medical practices while also serving to extract obedience from Mexico's racialized "Others." From Rodrigo's perspective,

> Oportunidades *is really* [an example of] *the dominant society practicing coercion over indigenous people*. [Translation from: *el programa Oportunidades es en realidad* [un ejemplo de] *las prácticas coercitivas infligidas a los indígenas por parte de la sociedad dominante*.]

As an outspoken critic of biopiracy and a proponent of indigenous knowledge, he argues that while traditional midwives' resistance to biomedical methods is deemed "backwardness" by medical professionals, traditional midwives are not interested in learning new techniques because they are confident about the effectiveness of the techniques they have been using for generations. He explained that while traditional midwives may attend training programs in order to continue receiving cash transfers and other government-provisioned services, they often do so with no intention of changing the methods they employ in their everyday practice of midwifery.

Rodrigo's assertions are supported by traditional midwives like Yanira who, during an in-depth interview, explained that women's participation in cash transfer programs has resulted in changes to what she reveals about her practice to authorities, but has not altered the substance of her midwifery. That is, women who receive support from *Oportunidades* tell her,

> *Don't give me a birth certificate. I am going to say that* [I couldn't make it to the hospital in time] *and gave birth alone at home. I am going to say that I was not attended by a midwife*. [Translation

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from: *no me des un acta de nacimiento, yo voy a decir que* [no llegué al hospital a tiempo], *y que di a luz sola en casa, y que no me atendió una partera*.]

However, my ethnographic research did not point to wholesale resistance. While indigenous informants often complied with Oportunidades mandates in ways that suggested engagement at the level of form instead of substance, I also observed how Oportunidades mandates structure the rhythm of indigenous womens' daily lives.

During my first trip to Zacatochin, I joined Francisca as she completed the requirements for her two-week "field practice." Among the requirements was to deliver a workshop to the villagers, educate them about reproductive health, and document the number of attendees as a measure of her "impact." Francisca went to the municipal offices to sign up to have her workshop announced throughout the village. Since there are no telecommunicative services in the village (no telephone, internet, etc.), announcements are made via an old Volkswagen Beetle that drives slowly along the winding mountainous pathway, blasting information through a megaphone attached to the roof.

The next day, Francisca and I went to the gathering place where community-wide workshops are held - cement basketball courts covered by corrugated metal, built with government funds to foster "community development." We waited, and no one arrived. Francisca decided to wait half an hour past the announced start time, and two women arrived. Disappointed in the meager turn out, Francisca half-heartedly delivered the workshop materials she had prepared, and then we walked back to our host's home.

That night, Francisca reflected on the disinterest in her workshop, and she decided that if villagers were uninterested in learning information that was to their benefit, they would have to be coerced. Furthermore, she refused to return from her "field practice" to report that the impact of her workshop had been the delivery of educational materials to two people. The next day, while I was at the village clinic interviewing the *médico pasante* [medical intern], Francisca returned to the municipal offices to announce another workshop. This time, she identified herself as someone who was coming to the village on behalf of the state-level Secretary of Health and that her workshop was mandated by *Oportunidades*. The next day, we returned to the basketball courts and prepared for the workshop. This time, over one-hundred and thirty members of the community, mostly women, attended. At the outset of the workshop, Francisca announced that at its conclusion she was going to take roll by asking to see each participants' voting registration card and cataloguing each person's name. This list, according to what she told participants, was going to be reviewed by the authorities at *Oportunidades* to determine compliance. In this way, Francisca insured that her audience remain captive until the end of her workshop.

As a professional midwifery student, Francisca was trained in medical terminology, and the intention of this "community engagement" experience was to allow her to develop the skills necessary to practice intercultural midwifery in rural settings. Francisca's presentation of reproductive health was littered with biomedical terms that were incomprehensible to workshop attendees and she failed to explain underlying physiological properties. The workshop "participants" stared blankly at her during most of the workshop. At the conclusion of the workshop, attendees lined up as Francisca took their identification cards one by one to write down their names.

This anecdote clearly highlights Francisca's abuse of power, evidencing how women with relatively greater privilege can also act as agents of structural inequality against other women. Moreover, it points to how conditional cash transfer programs like *Oportunidades* extract obedience from women recipients on the basis of their poverty and dependency on government-provisioned stipends. When the workshop was not a requirement for continued receipt of *Oportunidades* stipends, community members

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were almost universally disinterested. Subsequently, threat to *Oportunidades* stipends elicited compliance from village members. During private conversations, informants have expressed their annoyance at having to their daily routines disrupted and dictated by *Oportunidades* mandates. One mother reported feeling like "*a ball, bouncing from one place to another*." Instead of validating the intended positive effects of obligatory social services, the *Oportunidades* recipients I interviewed pointed to their frustration with the conditionality of the cash transfers and with forced compliance. I argue that programs like *Oportunidade*s are shaped by notions of "interculturality" that are valuable in theory, but contradictory in practice.

Interculturality

In Mexico, "interculturality" had emerged as a buzzword in government offices, academic circles, and a few hybrid clinics to describe respect for cultural differences through the merging of traditional indigenous medicine and biomedical methods. "Interculturality" is explicitly mentioned as a priority in the second article of the *Constitución Política de los Estados Unidos Mexicanos*[61] [Political Constitution of the United Mexican States], which guarantees an increase in scholastic levels and favors intercultural education. The article states,

> The nation has a pluricultural composition originally based in the indigenous peoples who are the descendants of those who inhabited the present-day territory of our country at the start of colonization and who preserve their own social, economic, cultural, and political institutions [...] Awareness of their indigenous identity should be a fundamental criteria for determining to whom regulations regarding indigenous peoples applies. [Translation from: *La nación tiene una composición pluricultural sustentada originalmente en sus pueblos indígenas que son aquellos que descienden de poblaciones que habitaban en el territorio actual del país al iniciarse la colonización y que conservan sus propias instituciones sociales, económicas, culturales y políticas* [...]. *La conciencia de su identidad indígena deberá ser criterio fundamental para determinar a quiénes se aplican las disposiciones sobre pueblos indígenas*.][61]

The article goes on to state that, in an effort to ameliorate the *rezagos* [backwardness] in indigenous communities, authorities are obligated to assure effective access to health services that make the most of traditional medicine, as well as support the nutrition of *indígenas* through food programs, especially for the child population (Article 2, Section B III). Furthermore, authorities are obligated to foster the incorporation of indigenous women into development through support for productive projects, the protection of women's health, and granting incentives to boost women's education and participation in decision-making related to community life (Article 2, Section B V).

I argue that notions of "interculturality" are ubiquitous in Mexico, and are thus woven into development programs like *Oportunidades* even when not explicitly stated. The Mexican government engages with its indigenous population through the (supposedly) benevolent and equitable framework of "interculturality." However, I examine the textual politics[38] of "interculturality" to uncover how this concept has been authored from positions of power as an approach to communities that are presumed inferior. The use of the word *rezago* in the Mexican constitution while describing various "intercultural" strategies points to the contradictory way *interculturalidad* in Mexico purports to equitably grant citizenship-based rights to indigenous community members while simultaneously casting indigenous people as "backward."

To try to understand the concept of "interculturality" better, I shared my observations and compared experiences with Jaime Breilh, Director of Health Sciences at Universidad

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Andina Simon Bolivar. He explained to me that in Ecuador, interculturality emerged as an indigenous movement, originating from the indigenous people. It has transformed not only into a political juncture, but an intellectual one as well. The people of Ecuador began applying their critical perspective to a colonial past, and the result was an epistemological and philosophical proposal for the future. In contrast, in Mexico "interculturality" did not originate from indigenous people; rather, it emerged as a theoretical debate in academia and a bureaucratic strategy in public health policy and development.

My ethnographic fieldwork suggests that "interculturality" is a powerful force for producing racialized subjects, arranging them hierarchically, and extending the material effects of those hierarchies. I am arguing against a naïve reading of "interculturality" – a liberal formulation that creates a utopian vision of a world of harmonic difference that exists apart from power. That is, "traditional" medicine and biomedicine do not come together on a level playing field, penetrating each other equally and evenly. The expert knowledge of physicians and traditional medicine doctors are not equally valued, they are not equally renumerated, nor are they equally supported by healthy policy and infrastructure. Often, when "interculturality" is celebrated, a series of persistent inequalities are ignored. I am wary of how unequal power dynamics, disparate perceptions of value, and ongoing racial discrimination can potentially be masked by emphasis on "interculturality," whether it be at the level of academic debate, or public health policy.

When performing fieldwork, I spoke to a variety of people in order to think through how "interculturality" is put into practice. A physician turned NGO leader and traditional medicine advocate spoke to me about different "intercultural" clinics around the country where traditional medicine is "butchered" and decontextualized, de-authenticated techniques are applied in isolated and incoherent ways. For example, in La Riviera Maya, one hospital installed hammocks in the waiting area as a "intercultural" strategy, while nothing was done to make the actual delivery of health care and therapeutics more culturally appropriate.

Meanwhile, efforts to develop more substantive forms of interculturality encounter obstacles when seeking funding. These obstacles stem from the fact that, despite the rhetoric of "interculturality" within policy, the legitimacy of counter-hegemonic models are severely questioned. One midwife, an adjunct professor at the Universidad Intercultural de Quintana Roo, told me "*intercultural models are not respected at all*. [Translation from: *los modelos interculturales no se respetan en absoluto*.]" The university at which she works is part of an emerging university system that attempts to incorporate indigenous knowledge into university-level education and requires students to study the Mayan language and learn about traditional medicine alongside biomedical methods. Nonetheless, the intercultural university model struggles to be acknowledged and valued within Mexican academia.

CONCLUSION

In this article, I have provided a number of examples of how indigenous women are discriminated against in clinical settings. Furthermore, I have suggested that trainings for traditional midwives and *Oportunidades* workshops for stipend recipients, undergirded by "interculturality" frameworks, may inadvertently reinscribe inequality. I argue that the unequal access to resources that indigenous women face and the differential treatment they receive are the results of racial i(nter)dentification: a process by which race, class, gender, education, and other forms of cultural capital intersect to shape how individuals perceive one another during encounters of difference. Thus, I argue that indigenous women encounter social challenges produced by the intersectionality of their indigeneity, poverty, gender, and lack of education, in addition to markers like their accent when speaking Spanish. These

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disadvantages converge as determinants of the inferior reproductive health care they receive.

I furthermore argue that while "interculturality" has gained popularity in Mexico, it has often been deployed in ways that inadvertently reinforce racial stereotypes while failing to substantively improve the quality of health care for intended recipients. Intercultural programs conceal a subscript regarding the inferiority and "backwardness" of indigenous groups, and decontextualized and de-authenticated forms of indigenous medicine in otherwise allopathic hospitals have failed to significantly unseat power inequalities between non-indigenous health care providers and indigenous patients. Intercultural tropes inform how the public health sector governs indigenous populations through programs like *Oportunidades*, which forcefully elicits obedience from impoverished stipend recipients. Meanwhile, indigenous mothers and midwives develop methods for obeying while also being agents of their own health.[2]

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